

Documentation for Autism Spectrum Disorders

The Office of Student Well-Being and Support (OWBS) provides support services and accommodations for students with documented disabilities. The treating or diagnosing healthcare professional should complete this form. Student Disability Services will use this form to evaluate eligibility for academic accommodations, which includes 1) disability diagnosis as defined under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990, as amended (ADAAA); 2) aid in the determination of appropriate services and accommodations in the academic environment.

The information provided by the health care professional will not become part of the student's educational records, but will remain in the student's confidential file in OWBS. Upon request, this form may be released only to the student. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment.

Please complete this form, fill out the Healthcare Provider Information section on the last page, sign it, then return it to the student, who will give it to OWBS at the College of Coastal Georgia.

Date of Birth

Print Name

Student ID#

Description of Diagnosis: _____

DSM/ICD code: _____ **Date of last visit to this provider:** _____

Date of original diagnosis: _____ **Diagnosed by:** _____

Describe cognitive ability as assessed using standardized assessment measures with age-appropriate norms. Identify assessment measures used and date. (Attach assessment reports if available.)

Describe limitations that affect this individual's ability to conduct one or more major life activities.

Describe the current limitations or impairments in social communication and interaction, and the degree of their impact on functioning. Include restricted or repetitive patterns of behavior, interests and activities and their impact in an academic environment.

Documentation for Autism Spectrum Disorders

Describe current functional limitations, which affect this individual in the academic setting, and suggestions for accommodations (i.e., note taker, extra time on tests).

Limitations

Recommendations

Healthcare Provider Information (In the space provided, please attach a business card.)

Provider Signature _____ Date _____

(Please print)

**Provider name: _____ Title: _____ License #: _____

Attach Business Card Here

Website: www.coga.edu/student-success-resources/office-of-student-well-being-and-support/accessibilityservices/

Brunswick Campus Location: Campus Center, Suite 232

Camden Center Location: 8001 Lakes Blvd., Kingsland, GA 31548

Email: owbs@coga.edu

Phone #: (912) 279-5804

Phone #: (912) 510-3300